110TH CONGRESS
1ST SESSION

S. 1340

To amend title XVIII of the Social Security Act to provide Medicare beneficiaries with access to geriatric assessments and chronic care coordination services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 9, 2007

Mrs. LINCOLN (for herself, Ms. COLLINS, Mr. KOHL, Mr. KERRY, Ms. MIKULSKI, Mrs. CLINTON, Mrs. BOXER, and Mr. CASEY) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide Medicare beneficiaries with access to geriatric assessments and chronic care coordination services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Geriatric Assessment and Chronic Care Coordination Act of 2007''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Medicare coverage of geriatric assessments.
Sec. 4. Medicare coverage of chronic care coordination services.
Sec. 5. Outreach activities regarding geriatric assessments and chronic care coordination services under the Medicare program.
Sec. 6. Study and report on geriatric assessments and chronic care coordination services under the Medicare program.
Sec. 7. Study and report on best practices for Medicare chronic care coordination.
Sec. 8. Rule of construction.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The Medicare program must be redesigned to provide high-quality, cost-effective care to the growing population of elderly individuals with multiple chronic conditions.

(2) According to the Congressional Budget Office, approximately 43 percent of Medicare costs can be attributed to 5 percent of Medicare's most costly beneficiaries.

(3) Currently, 78 percent of the Medicare population has at least 1 chronic condition, and ⅔ have more than 1 chronic condition. The 20 percent of beneficiaries with 5 or more chronic conditions account for ⅔ of all Medicare spending. In addition, the large baby boomer generation is moving toward retirement and Medicare eligibility.

(4) The prevalence of chronic conditions increases with age: 74 percent of the 65- to 69-year-old group has at least 1 chronic condition, while 86 percent of the 85 years and older group has at least 1 chronic condition. Similarly, just 14 percent of the 65- to 69-year-old group has 5 or more chronic conditions, while 28 percent of the 85 years and older group has 5 or more chronic conditions.

(5) There is a strong pattern of increasing utilization as the number of conditions increase. Fifty-five percent of Medicare beneficiaries with 5 or more conditions experienced an inpatient hospital stay compared to 5 percent of those with 1 condition or 9 percent of those with 2 conditions.

(6) In terms of physician visits, the average Medicare beneficiary has over 15 physician visits annually and sees 6 different physicians annually.

(7) When Alzheimer's disease or other form of dementia are present along with 1 or more other chronic conditions, utilization also increases. For example, in 2000, total average per person Medicare expenditures for those with congestive heart failure and Alzheimer's or dementia were 47 percent higher than for those with congestive heart failure and no dementia.

(8) Research conducted in the United States and internationally indicate that the delivery of higher quality health care, increased efficiency, and cost-effectiveness are the result of systems in which patients are linked with a physician or another qualified health professional who coordinates their care.

(9) The current Medicare program does not reward physicians for integrating and coordinating health care because these services are not explicitly recognized and distinctly paid for. Instead, physicians are incentivized to provide episodic care and to generate more individual patient visits to the doctor's office and hospital for separately reimbursed tests and procedures.

(10) The chronic care model established by this Act includes several elements that are effective in managing chronic disease, including—

(A) linkages with community resources;

(B) health care system changes that reward quality chronic care;

(C) support for patient self-management of chronic disease;

(D) practice redesign;

(E) evidence-based clinical practice guidelines; and

(F) clinical information systems, such as electronic medical records and continuity of care records.

(11) Financial incentives within the Medicare program should be realigned as part of a comprehensive system change. The Medicare program should be restructured to reimburse physicians and other qualified health professionals for the cost of coordinating care.

(12) The provisions of, and amendments made by, this Act are intended to—

(A) create savings to the Medicare program;

(B) establish a process to identify those Medicare beneficiaries most likely to benefit from having a provider coordinate their health care needs; and

(C) establish a payment under the Medicare program for—

(i) the assessment of those health care needs; and

(ii) the activities required to coordinate those health care needs.

SEC. 3. MEDICARE COVERAGE OF GERIATRIC ASSESSMENTS.

(a) COVERAGE OF GERIATRIC ASSESSMENTS.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (Z), by striking ''and'' at the end;

(B) in subparagraph (AA), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(BB) geriatric assessments (as defined in subsection (ccc)(1));''.

(2) CONFORMING AMENDMENTS.—(A) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)) is amended by striking ''or (K)'' and inserting ''(K), or (BB)''.

(B) Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (ccc)(1)''.

(b) GERIATRIC ASSESSMENTS DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is

amended by adding at the end the following new subsections:

''Geriatric Assessment

''(ccc)(1) The term 'geriatric assessment' means each of the following:

''(A) An assessment of the clinical status, functional status, social and environmental functioning, and need for caregiving of a geriatric assessment eligible individual (as defined in subsection (ddd)). The assessment shall include a comprehensive history and physical examination and assessments of the following domains using standardized validated clinical tools:

''(i) Comprehensive review of medications and the individual's adherence to the medication regimen.

''(ii) Measurement of affect, cognition and executive function, mobility, balance, gait, risk of falling, and sensory function.

''(iii) Social functioning, environmental needs, and caregiver resources and needs.

''(iv) Any other domain determined appropriate by the Secretary.

''(B) Subsequent assessments, which may not be conducted more frequently than annually, unless

the subsequent assessment is medically necessary due to a significant change in the condition of the geriatric assessment eligible individual.

''(C) The development of a written care plan based on the results of the assessment under subparagraph (A) (and any subsequent assessment under subparagraph (B)). The care plan shall detail identified problems, outline therapies, assign responsibility for actions, and indicate whether the individual is likely to benefit from chronic care coordination services (as defined in subsection (eee)(1)). If the individual is determined likely to benefit from chronic care coordination services, the care plan shall also provide the basis for the chronic care coordination plan to be developed by the chronic care manager pursuant to subsection (eee).

''(2) A geriatric assessment may only be conducted by—

''(A) a physician;

''(B) a practitioner described in section 1842(b)(18)(C)(i) under the supervision of a physician; or

''(C) any other provider that meets such conditions as the Secretary may specify.

''Geriatric Assessment Eligible Individual

''(ddd)(1) Subject to paragraph (3), the term 'geriatric assessment eligible individual' means an individual identified by the Secretary as eligible for a geriatric assessment.

''(2) In identifying individuals under paragraph (1), the following rules shall apply:

''(A) The individual must have at least 1 of the following present:

''(i) Multiple chronic conditions.

''(ii) Dementia, as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, and at least 1 chronic condition.

''(iii) Any other factor identified by the Secretary.

''(B)(i) The individual, as determined by the Secretary—

''(I) must have aggregate medical costs under this title in the top 10 percent of all applicable individuals during the previous 36 months; or

''(II) is likely to incur costs under this title in the top 10 percent of all applicable individuals during the current or subsequent calendar year.

''(ii) The determination under clause (i)(II) of future costs shall be based on the medical condition of the individual, the individual's past cost to the program under this title, and other factors as identified by the Secretary.

''(iii) The individual meets such additional criteria (if any) as the Secretary establishes under subparagraph (C).

''(C)(i) If the Secretary estimates that the total number of applicable individuals that would be geriatric assessment eligible individuals in a year (but for this subparagraph) exceeds 10 percent of the total number of applicable individuals in the year, the Secretary shall establish and apply under subparagraph (B)(iii) such additional criteria as is designed to eliminate such excess.

''(ii) The Secretary shall consult with physicians, physician groups, organizations representing individuals with chronic conditions and older adults, and other stakeholders in identifying any additional criteria under clause (i).

''(D) For purposes of this paragraph, the term 'applicable individual' means an individual enrolled for benefits under part B but not enrolled in a Medicare Advantage plan or a plan under section 1876.

''(3) The term 'geriatric assessment eligible individual' shall not include the following individuals:

''(A) An individual who is receiving hospice care under this title.

''(B) An individual who is residing in a skilled nursing facility, a nursing facility (as defined in section 1919), or any other facility identified by the Secretary.

''(C) An individual medically determined to have end-stage renal disease.

''(D) An individual enrolled in a Medicare Advantage plan or a plan under section 1876.

''(E) An individual enrolled in a PACE program under section 1894.

''(F) Any other categories of individuals determined appropriate by the Secretary.

''(4) For purposes of this subsection, the term 'chronic condition' means a condition, such as dementia, that lasts or is expected to last 1 year or longer, limits what an individual can do, and requires ongoing care.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (N), by inserting ''other than geriatric assessments (as defined in section 1861(ccc)(1))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(V)''; and

(C) by inserting before the semicolon at the end the following: '', and (W) with respect to geriatric assessments (as defined in section 1861(ccc)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(BB),'' after ''(2)(AA),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammog-

raphy, or geriatric assessments (as defined in section 1861(ccc)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' at the end;

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (G)(ii) the following new subparagraph:

''(H) with respect to geriatric assessments (as defined in section 1861(ccc)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W),''.

(4) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(8)''; and

(B) by inserting before the period the following: '', and (9) such deductible shall not apply with respect to geriatric assessments (as defined in section 1861(ccc)(1))''.

(d) FREQUENCY LIMITATION.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (M);

(2) by striking the semicolon at the end of subparagraph (N) and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(O) in the case of geriatric assessments (as defined in section 1861(ccc)(1)), which are performed more frequently than is covered under such section;''.

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

''(6) GERIATRIC ASSESSMENTS.—In the case of a designated health service, if the designated health service is a geriatric assessment (as defined in section 1861(ccc)(1)) and furnished by a physician.''.

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms, establish such procedures, and promulgate such regulations as the Secretary determines necessary to implement the amend-

ments made by, and the provisions of, this section, including the establishment of additional domains under subsection (ccc)(1)(A)(iv) of section 1861 of the Social Security Act, as added by subsection (b). In promulgating such regulations, the Secretary shall consult with physicians, physician groups and organizations, and organizations representing individuals with chronic conditions and older adults.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to assessments furnished on or after January 1, 2008.

SEC. 4. MEDICARE COVERAGE OF CHRONIC CARE COORDINATION SERVICES.

(a) PART B COVERAGE OF CHRONIC CARE COORDINATION SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 3(a)(1), is amended—

(A) in subparagraph (AA), by striking ''and'' at the end;

(B) in subparagraph (BB), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(CC) chronic care coordination services (as defined in subsection (eee));''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)), as amended by section 3(a)(2)(A), is amended by striking ''or (BB)'' and inserting ''(BB), or (CC)''.

(B) Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)), as amended by section 3(a)(2)(B), are each amended by striking ''subsections (ww)(1) and (ccc)'' and inserting ''subsections (ww)(1), (ccc), and (eee)''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 3(b), is amended by adding at the end the following new subsection:

''Chronic Care Coordination Services; Chronic Care Manager; Chronic Care Eligible Individual

''(eee)(1) The term 'chronic care coordination services' means services that are furnished to a chronic care eligible individual (as defined in paragraph (3)) by a single chronic care manager (as defined in paragraph (2)) chosen by the individual under a plan of care prescribed by such chronic care manager for the purpose of chronic care and

dementia coordination, which may include any of the following services:

''(A) The development of an initial plan of care (based on the results of a geriatric assessment, as defined in subsection ccc)), and subsequent appropriate revisions to that plan of care.

''(B) The management of, and referral for, medical and other health services, including interdisciplinary care conferences and management with other providers.

''(C) The monitoring and management of medications.

''(D) Patient education and counseling services.

''(E) Family caregiver education and counseling services.

''(F) Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.

''(G) Providing access by telephone with physicians and other appropriate health care professionals, including 24-hour availability of such professionals for emergencies.

''(H) Management with the principal nonprofessional caregiver in the home.

''(I) Managing and facilitating transitions among health care professionals and across settings of care, including the following:

''(i) Pursuing the treatment option elected by the individual.

''(ii) Including any advance directive executed by the individual in the medical file of the individual.

''(J) Information about, and referral to, hospice care, including patient and family caregiver education and counseling about hospice care, and facilitating transition to hospice care when elected.

''(K) Information about, referral to, and management with, community services.

''(L) Such additional services for which payment would not otherwise be made under this title that the Secretary may specify that encourage the receipt of, or improve the effectiveness of, the services described in the preceding subparagraphs.

''(2)(A) For purposes of this subsection, the term 'chronic care manager' means an individual or entity that—

''(i) is—

''(I) a physician;

"(II) a practitioner described in clause (i) or (iv) of section 1842(b)(18)(C) under the supervision of a physician; or

"(III) any other provider that meets such conditions as the Secretary may specify; and

"(ii) has entered into a chronic care coordination agreement with the Secretary.

"(B)(i) For purposes of subparagraph (A)(ii), each chronic care coordination agreement shall meet the requirements described in subparagraph (C) and shall—

"(I) subject to clause (ii), be entered into for a period of 3 years and may be renewed if the Secretary is satisfied that the chronic care manager continues to meet such terms and conditions as the Secretary may require; and

"(II) contain such other terms and conditions as the Secretary may require.

"(ii) Each chronic care coordination agreement shall provide for the termination of such agreement prior to such 3-year period in the case where the chronic care manager—

"(I) is no longer able to provide chronic care services; or

"(II) does not meet such terms and conditions as the Secretary may require.

''(C)(i) Subject to clause (ii), the requirements of this subparagraph are met if the agreement requires the chronic care manager to perform, or provide for the performance of, the following services:

''(I) Advocating for, and providing ongoing support, oversight, and guidance with respect to the implementation of a plan of care that provides an integrated, coherent, and cross-disciplined plan for ongoing medical care that is developed in partnership with the chronic care eligible individual and all other physicians and other care providers and agencies (including home health agencies) providing care to the chronic care eligible individual.

''(II) Using evidence-based medicine and clinical decision support tools to guide decision making at the point of care and on the basis of specific patient factors.

''(III) Using health information technology, including, where appropriate, remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

''(IV) Encouraging patients to engage in the management of their own health through education and support systems.

''(V) Incorporating family caregivers into the chronic care planning process.

''(ii) The Secretary may modify the services required under the agreement under clause (i), including by requiring different services or services in addition to those described in subclauses (I) through (V) of such clause.

''(D) The Secretary shall adopt procedures which exempt providers in rural areas from providing 1 or more of the services otherwise required to be provided under subparagraph (C) or modify such requirements for such providers. In establishing such procedures, the Secretary shall ensure that such exemptions and modifications do not impact the quality of chronic care coordination services furnished by such providers.

''(3) For purposes of this subsection, the term 'chronic care eligible individual' means a geriatric assessment eligible individual (as defined in subsection (ddd)) who has undergone a geriatric assessment (as defined in subsection (ccc)(1)) which determined that the individual would benefit from chronic care coordination.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security

Act (42 U.S.C. 1395l(a)(1)), as amended by section 3(c)(1), is amended—

(A) in subparagraph (N), by inserting ''or chronic care coordination services (as defined in section 1861(eee))'' after ''other than geriatric assessments (as defined in section 1861(ccc)(1))'';

(B) by striking ''and'' before ''(W)''; and

(C) by inserting before the semicolon at the end the following: '', and (X) with respect to chronic care coordination services (as defined in section 1861(eee)), the amount paid shall be 100 percent of the amount determined under section 1848(m)''.

(2) PAYMENT.—

(A) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(m) PAYMENT FOR CHRONIC CARE COORDINATION SERVICES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish a monthly care coordination payment amount under this section for chronic care co-

ordination services (as defined in paragraph (1) of section 1861(eee)(1)) furnished to a chronic care eligible individual (as defined in paragraph (3) of such section) by a chronic care manager (as defined in paragraph (2) of such section 1861).

''(B) REQUIREMENTS.—In establishing payment amounts under subparagraph (A), the Secretary shall—

''(i) take into account the time required of the chronic care manager in providing the care coordination services to chronic care eligible individuals and the costs associated with the practice-level health information technologies and systems incurred by the chronic care manager in providing such services; and

''(ii) ensure that such payments do not result in a reduction in payments for office visits or other evaluation and management services that would otherwise be allowable.

''(2) CODE.—Under the conditions set forth in this section, the Secretary shall develop a care co-

ordination payment code for chronic care coordination services and a value for such code.

''(3) SEPARATE PAYMENTS FROM PAYMENTS FOR GERIATRIC ASSESSMENTS.—Payments for chronic care coordination services shall be made separately from payments for geriatric assessments (as defined in section 1861(ccc)(1)) and other services for which payment is made under this title.''.

(B) CONFORMING AMENDMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 3(c)(2)), is amended by inserting ''(2)(CC),'' after ''(2)(BB),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 3(c)(3)(A), is amended by striking ''or geriatric assessments (as defined in section 1861(ccc)(1))'' and inserting ''geriatric assessments (as defined in section 1861(ccc)(1)), or chronic care coordination services (as defined in section 1861(eee)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)), as amended by section 3(c)(3)(B), is amended—

(i) in subparagraph (G)(ii), by striking ''and'' at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (H) the following new subparagraph:

''(I) with respect to chronic care coordination services (as defined in section 1861(eee)(1)) furnished by an outpatient department of a hospital, the amount determined under section 1848(m),''.

(4) ELIMINATION OF DEDUCTIBLE.—Paragraph (9) of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as added by section 3(c)(4), is amended by inserting ''or chronic care coordination services (as defined in section 1861(eee)(1))'' after ''geriatric assessments (as defined in section 1861(ccc)(1))''.

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C.

1395u(b)(18)(C)) is amended by adding at the end the following new clause:

"(vii) A chronic care manager (as defined in section 1861(eee)(2)) that is not a physician.".

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b)(6) of the Social Security Act (42 U.S.C. 1395nn(b)(6)), as amended by section 3(e), is amended to read as follows:

"(6) GERIATRIC ASSESSMENTS AND CHRONIC CARE COORDINATION SERVICES.—In the case of a designated health service, if the designated health service is—

"(A) a geriatric assessment or a chronic care coordination service (as defined in subsections (ccc)(1) or (eee)(1) of section 1861, respectively); and

"(B) provided by a physician or a chronic care manager (as defined in section 1861(eee)(2)).".

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms, establish such procedures, and promulgate such regulations as the Secretary determines necessary to implement the amendments made by, and the provisions of, this section. In promulgating such regulations, the Secretary shall consult

with physicians, physician groups and organizations, and organizations representing individuals with chronic conditions and older adults.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to chronic care coordination services furnished on or after January 1, 2008.

SEC. 5. OUTREACH ACTIVITIES REGARDING GERIATRIC ASSESSMENTS AND CHRONIC CARE COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

The Secretary of Health and Human Services shall conduct outreach activities to individuals likely to be eligible to receive coverage of geriatric assessments (as defined in subsection (ccc) of section 1861 of the Social Security Act, as added by section 3) under the Medicare program and individuals likely to be eligible to receive coverage of chronic care coordination services (as defined in subsection (eee) of such section 1861, as added by section 4) under the Medicare program, to inform such individuals about the availability of such benefits under the Medicare program.

SEC. 6. STUDY AND REPORT ON GERIATRIC ASSESSMENTS AND CHRONIC CARE COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with an entity to conduct a study on—

(1) the effectiveness of the coverage of geriatric assessments and chronic care coordination services under the Medicare program (under the amendments made by sections 3 and 4) on improving the quality of care provided to Medicare beneficiaries with chronic conditions, including dementia; and

(2) the impact of such geriatric assessments and care coordination services on reducing expenditures under title XVIII of the Social Security Act, including reduced expenditures that may result from—

(A) reducing preventable hospital admissions;

(B) more appropriate use of pharmaceuticals; and

(C) reducing duplicate or unnecessary tests.

(b) REPORT.—Not later than 3 years after the date of enactment of this Act, the entity conducting the study under subsection (a) shall submit to Congress and the Sec-

retary of Health and Human Services a report on the study, together with recommendations for such legislation or administrative action as such entity determines appropriate.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 7. STUDY AND REPORT ON BEST PRACTICES FOR MEDICARE CHRONIC CARE COORDINATION.

(a) STUDY.—The Secretary of Health and Human Services, in consultation with the Medicare Payment Advisory Commission, shall conduct a study of the following issues:

(1) The effectiveness of pay-for-performance programs to serve Medicare beneficiaries with multiple chronic conditions, including dementia.

(2) The cost-effectiveness of chronic care coordination under the Medicare program.

(3) Whether the quality measures used for making payments under part B of the Medicare program, including the measures developed under subsection (k) of section 1848 of the Social Security Act (as added by section 101 of division B of the Tax Relief and Health Care Act of 2006, Public Law 109–432), improve the quality of care provided to

Medicare beneficiaries with multiple chronic illnesses, including dementia.

(b) REPORT.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a) that contains—

(1) recommendations on the best quality indicators for monitoring the chronic care coordination of the conditions of Medicare beneficiaries with multiple chronic conditions, including dementia; and

(2) such other recommendations for legislation or administrative action as the Secretary determines appropriate.

SEC. 8. RULE OF CONSTRUCTION.

Nothing in this Act, or in the amendments made by this Act, shall be construed as requiring an individual to receive a geriatric assessment (as defined in section 1861(ccc)(1) of the Social Security Act, as added by section 3(b)) or chronic care coordination services (as defined in section 1861(eee)(1) of such Act, as added by section 4(b)).

○